CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/26/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155653		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 08/05/2011			
NAME OF PROVIDER OR SUPPLIER  LAKE COUNTY NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 5025 MCCOOK AVE EAST CHICAGO, IN46312					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE	(X5) COMPLETION DATE	
F0000	This visit was for Complaint IN000 Complaint IN000 Federal/State def allegations are cir F282 and F425.  Complaint IN000 deficiencies relaticited.	the Investigation of 094047 and IN00094361. 094047- Substantiated, ficiencies related to the ted at 094361- Substantiated no ed to the allegations are 194361- Substantiated no ed to the allegations are 1900108 155653 100267410	FO	000				
LADORATOR	V DIDECTORIC OF PROV	Then clindlied deddesentatives sid			TITI E		(V6) DATE	

(X6) DATE

Any defiencystatement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING 00		00	COMPLETED	
1556		155653	B. WING 08/05			08/05/2	011
		<u> </u>	D. 1121		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER				5025 M	CCOOK AVE		
	OUNTY NURSING 8	REHABILITATION CENTER		L	CHICAGO, IN46312		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	•	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E E	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	•	TAG	DEFICIENCY)		DATE
	Findings cited in IAC 16.2.	es also reflect State accordance with 410 ompleted on August 11, alkner, RN					
F0282 SS=D	facility must be proin accordance with plan of care.  Based on record facility failed to were followed for reviewed related medications order (Resident #D)  Findings include		F0	Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. A medication and cart audit was completed for resident D. The physician discontinued the order for Aranesp for resident D. All facility residents who have physician orders for medications have the potential to be affected by the same alleged deficient practice. A list of residents who have physician orders for Aransep was compiled. The medication and cart audit was completed for facility residents. The DON in serviced nurses on the importance of following physician's orders, there is no such thing as an unavailable medication, and what steps are to be taken if the medication is not		on of e an by only	09/04/2011
	on 8/4/11 at 9:45 diagnoses includ to, diabetes melli (blood clot), hyp disease, congesti and anemia.  Review of the 7/ Statement, indicareceive Aranesp	esident #D was reviewed a.m. The resident's ed, but were not limited itus, venous thrombosis ertension, chronic kidney we heart failure, obesity, 8/11 Physician Order ated the resident was to (medication used to treat g (micrograms) injected				n the e ce. was nd ON in o	

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FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

3JZJ11

Facility ID:

000108

If continuation sheet

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F0425 SS=D	spoken to the phawas ordered on 7 signature needed Nursing before the sent to the facility the 7/21/11 dose pharmacy and the received the Aran This Federal tag IN00094047.  3.1-35(g)(2)  The facility must premergency drugs residents, or obtain described in §483 facility may permit administer drugs it under the general nurse.  A facility must proviservices (including administering of all meet the needs of The facility must e of a licensed pharmacy and the services of the facility must even facility even fac	relates to complaint  rovide routine and and biologicals to its in them under an agreement (7.5(h)) of this part. The unlicensed personnel to its state law permits, but only supervision of a licensed vide pharmaceutical procedures that assure the procedures that assure the procedures and biologicals) to each resident.  In the provides aspects of the provision of						

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000108

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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	noted to be slow answered questic resident was reast complaints of did discomfort. The have a loose stool low blood pressuphysician was in received to send hospital for evaluating note of 7 resident remaine.  Interview with the 8/5/11 at 2:30 p.m. spoken to the phemedication was a there was a signar Director of Nurs would be sent to indicated the 7/2 from pharmacy a received the Aran	ons appropriately. The sesses and had no exziness, headache or resident was noted to ol and continued to have are. At 1:35 p.m., the formed and an order was the resident to the mation and treatment. A 1/27/11 indicated the dispitalized.  The Nurse Consultant on m., indicated she had armacy and the ordered on 7/20/11 but atture needed from the ing before the medication the facility. She further 1/11 dose was never sent and the resident did not		promptly addressed. A summon of the audits will be present the Quality Assurance commonthly by the ADON and/ordesignee for three months. Thereafter, if determined by Quality Assurance committed auditing and monitoring will done quarterly and present quarterly at the Quality Assurance in Monitoring will be going.	ed to mittee or the ee, be ed urance			